

UCSF Birth Center

Care Map Post Cesarean-Hysterectomy

**** This pathway is intended to call out things that are different for a patient who has had a hysterectomy.****

*****Please continue routine standards of care for all else (vital signs, I&O, wound assessments, etc.)*****

RN on each shift to complete and handoff for continuity of care.	
PRE-OP	<input type="checkbox"/> Usually admitted the night before (for IV, labs, consults, etc.) <input type="checkbox"/> If needed: arrange for in-house translator for Pre-Op/Consults <input type="checkbox"/> Anesthesia consult/check in by night team <input type="checkbox"/> Complete Admission & Pre-Op Checklist Night Shift Nursing – night before surgery: <input type="checkbox"/> Chlorhexidine wash for shower before surgery (night before or morning of) <input type="checkbox"/> Give Boost Breeze to drink at least 2 hours before surgery (unless patient has diabetes) <input type="checkbox"/> NST around 530 am (for 730/8am start, can be later if case is later) <input type="checkbox"/> Make sure all consents in chart, including sterilization consent for hysterectomy <input type="checkbox"/> Sage prep before going to Pre-Op <input type="checkbox"/> If patient interested in breast feeding, teach use of the breast pump (before case or on days) <input type="checkbox"/> Teach patient use of the incentive spirometer <input type="checkbox"/> Gather the following supplies to go with patient to pre-op: <ul style="list-style-type: none"> <input type="checkbox"/> Portable fetal monitor fully stocked with paper, gel, monitor parts (usually in OR but check) <input type="checkbox"/> Bring PPH mobile cart <input type="checkbox"/> Bring QBL Scale <input type="checkbox"/> Bring Vacuum (Kiwi) <input type="checkbox"/> Bring Banjo <input type="checkbox"/> Make sure T&S and ABO confirmation are current and blood is available (per MD order) <input type="checkbox"/> Sterile cord blood bank tubes <input type="checkbox"/> 2 cord blood gas syringes <input type="checkbox"/> Baby papers (i.e. half sheet, APGAR sheet for peds) <input type="checkbox"/> Baby bands (or extra mom band-even if ICN baby) <input type="checkbox"/> Please prioritize giving report to pre-op when they call to avoid any delays in patient transport downstairs (pre-op 6-0989) When sending patient to pre-op: <ul style="list-style-type: none"> <input type="checkbox"/> Make sure pre-op nursing has received report before you leave the Birth Center <input type="checkbox"/> Make sure chart and consents go with pt <ul style="list-style-type: none"> • Night Shift RN does not need to go unless continuous monitoring is ordered • Day Shift RN should get report and immediately go to pre-op

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RN on each shift to complete and handoff for continuity of care.	
INTRA-OP	<p>Nursing:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Be available to assist OR staff in checking blood before start of case <input type="checkbox"/> Monitor fetus in the OR as directed <input type="checkbox"/> If stents are being placed, remind OR staff NOT to prep the abdomen until after stents are placed unless non-viable fetus <input type="checkbox"/> Fetus should be monitored as much as possible in the OR until skin is prepped. <input type="checkbox"/> Help with OR crowd control (remind waiting teams (i.e. Peds) to be as quiet as possible) <input type="checkbox"/> Document: <ul style="list-style-type: none"> <input type="checkbox"/> Fetal heart tracing and times <input type="checkbox"/> All applicable components on the delivery record <input type="checkbox"/> Prior to case start, ask Scrub tech/RN for a wet lap and take note (for QBL, as this is not standard procedure) <input type="checkbox"/> Remind OB resident to fill out the pathology requisition with the information listed on the MAPS Problem List checklist <input type="checkbox"/> Remind OB resident to place intra-op US order (if not already done by OR Nurse)
PACU	<p>All Pain Management Orders per OB Anesthesia until pain is stable and then managed by OB.</p> <p>Nursing/Anesthesia:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Gum chewing per protocol <input type="checkbox"/> Make sure SCD turned on and working <input type="checkbox"/> Incentive spirometer use to start in PACU with 10 times/hr while awake <input type="checkbox"/> Start clear liquids as tolerated <input type="checkbox"/> Handoff with anesthesia for pain care plan. If thoracic epidural present, it will be managed by nursing for bag changes, rate, etc.

RN on each shift to complete and handoff for continuity of care.

**POST-OP
 DAY #0**

If the patient has an epidural (thoracic or lumbar) - ALL Pain Management Orders per OB Anesthesia until the epidural is discontinued (typically POD2).

If there is no epidural present – Pain management will be directed by Obstetrics once the patient leaves PACU.

Pain Mgmt in PP:

Acetaminophen and Ketoralac may be held **per MD for medical conditions**

- Acetaminophen **per order** ATC (1st dose 6/8 hr after pre-op dose)
- Ketoralac **per order** ATC x 3 doses (check if 1st dose given in PACU or by anesthesia; if yes, make sure noted on MAR)
- Oxycodone 5-10mg PO q 3 hr PRN moderate pain
- Epidural handoff each shift to include verifying amount left in epidural bag (epidural bags managed by nursing)

Nursing:

- DVT prophylaxis: SCDs on and running when in bed, if prophylactic anticoagulant is ordered:
 - Lovenox: **NOT given while epidural in place.** Usually started ~12 hours after epidural removal.
 - Heparin: **sometimes may be started** while epidural is in place. Usually started ~6 hours after epidural removal/spinal insertion
- Patients can walk with a thoracic epidural in place after orthostatics done
 - Dangle by 8-12 hr post-op
 - Ambulate by 24 hr post-op (get them walking when pain control allows)
- Remove foley when patient is safely ambulating, watch carefully for urinary retention if epidural is still running
- Encourage incentive spirometer 10 times/hr while awake
- Advance diet to Regular as appropriate (patients should be eating by POD 1 at the latest, can eat whenever tolerated)

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RN on each shift to complete and handoff for continuity of care.

POST-OP DAY #1

If the patient has an epidural thoracic or lumbar - ALL Pain Management Orders per OB Anesthesia until the epidural is discontinued (typically POD2)

If there is no epidural present – Pain management will be directed by Obstetrics once the patient leaves PACU.

Pain Mgmt in PP:

Acetaminophen and Ketorolac may be held **per MD for medical conditions**

- Acetaminophen **per order** ATC
- Finish ketorolac **per order** ATC x 3 doses then start:
- Ibuprofen PO **per order** ATC after ketorolac completed
- Oxycodone 5-10mg PO q 3 hr PRN moderate pain
- Epidural handoff each shift to include verifying amount left in epidural bag (epidural bags managed by nursing)

Nursing:

- DVT prophylaxis: SCDs on and running when in bed; prophylactic anticoagulant if ordered
 - Lovenox: **NOT given while epidural in place**. Usually started ~12 hours after epidural removal.
 - Heparin: **sometimes may be started** while epidural is in place. Usually started ~6 hours after epidural removal/spinal insertion
- Ambulation: get them up and moving early and often!
- Encourage ambulation
- Patient to sit in chair for all meals
- Encourage incentive spirometer 10 times/hr while awake
- Advance diet to Regular if not already done
- Give Miralax daily until regular bowel movements (be proactive on bowel regimen as hysterectomy patients will use more narcotics than c/s patients and their bowels are manipulated more during surgery)

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RN on each shift to complete and handoff for continuity of care.	
POST-OP DAY #2 until discharge	<p>If the patient has an epidural thoracic or lumbar - ALL Pain Management Orders per OB Anesthesia until the epidural is discontinued (typically POD2)</p> <p>If there is no epidural present – Pain management will be directed by Obstetrics once the patient leaves PACU.</p> <p>Pain Mgmt in PP: **Acetaminophen and Ketoralac may be held per MD for medical conditions**</p> <ul style="list-style-type: none"> <input type="checkbox"/> Acetaminophen per order ATC <input type="checkbox"/> Ibuprofen per order ATC <input type="checkbox"/> Oxycodone 5-10mg PO q 3 hr PRN moderate pain <input type="checkbox"/> D/C thoracic epidural (if not already done) <p>Nursing:</p> <ul style="list-style-type: none"> <input type="checkbox"/> DVT prophylaxis: SCDs on and running when in bed, prophylactic anticoagulant if ordered <input type="checkbox"/> If patient will go home on DVT prophylaxis, please initiate teaching of self-administration by POD #2 <input type="checkbox"/> Ambulation: get them up and moving early and often! <ul style="list-style-type: none"> <input type="checkbox"/> Encourage ambulation several times per day (at least 3) <input type="checkbox"/> Patient to sit in chair for all meals <input type="checkbox"/> Encourage incentive spirometer 10 times/hr while awake <input type="checkbox"/> Remember: hysterectomy pts will have significantly more pain than a c/s patient. This is normal. <p>Please medicate appropriately for pain to goals of: ambulation, eating, sleeping, holding/visiting baby, breast pumping</p> <ul style="list-style-type: none"> <input type="checkbox"/> Give Miralax daily until regular bowel movements (be proactive on bowel regimen as hysterectomy patients will use more narcotics than c/s patients and their bowels are manipulated more during surgery)
D/C GOALS	<ul style="list-style-type: none"> <input type="checkbox"/> Controlled on oral pain medications well enough to ambulate, eat, sleep, hold/visit baby, breast pump <input type="checkbox"/> Voiding and having BMs <input type="checkbox"/> Ambulate without assist <input type="checkbox"/> DVT prophylaxis self-administration teaching completed (if ordered) <input type="checkbox"/> Confirm follow up appointment plan (appt made with UCSF provider vs. appt with home OB provider)